October 15, 2004

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TWCC Medical Dispute Resolution
MS-48
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MDR Tracking #: M2-05-0116-01-SS
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor board certified and specialized in Orthopaedic Surgery. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

This patient appears to have had other cervical spine injuries, one of which resulted in anterior cervical spine fusion at C 6-7. The current level of concern is the mediate superior adjacent disk level, where after a fall from a chair, which was stopped by an unseen cable. The patient had a new onset of neck pain radiating to the right upper extremity. His medical records reveal what appears to be a cascading symptom. The initial consultation two months post injury revealed neck pain, but no objective findings of weakness, motor or sensory deficits. Radiograph shows spondylitic changes at C 5-6, previous fusion at C 6-7. An MRI revealed right-sided herniation at C5-6 nearing the injury aspect of the right neuroforamen and partially effacing the right anterior lateral aspect of the thecal sac. There are also osteophytes noted at C 3-4, C 4-5 on the left, and the adjacent level inferior at C-7, T-1 was unremarkable. The requesting physician reported in his initial consultation that this was a new finding, but recommended surgical intervention based on the lacking improvement over two months of conservative care, and opined that based on the history of failed conservative treatment years ago from a previous surgery, that conservative care would unlikely be successful in this case as well. However, he admitted that there was no evidence of thoracic radiculopathy. One month later, the attending physician saw the patient back and now reports progressive motor deficit with weakness in wrist extension, finger extension, finger flexion, elbow extension along the C 6-7 motor division. There is also a report of C-6

essential radiculopathy and dysesthias. Having been denied proposed surgery, the attending physician challenged the report one moment in time while in physical therapy that the pain was gone.

Two previous preauthorization reviews declined the medical necessity of this proposed surgery. The first review two months post injury opined that the surgery was not medically necessary since there is no inflammation regarding conservative treatment including selective nerve root injection, and that there is a discrepancy from the official MRI report, and the requesting physician's interpretation. He recommended that discussion be provided before approval could be submitted. Apparently, this discussion was never carried out. The second request for surgery approximately one month later declined the request for surgery based on a conflict between patient symptoms, between being completely pain free, and continued symptoms reported by two different providers. It was felt that there was an inconsistent examination based on the MRI findings, and the second denial was submitted in the pre-authorization process.

Unfortunately, an RME performed in September, approximately one month since the last attending physician's report, approximately ___ months post injury, was submitted for perusal but was incomplete in its content. The RME dated 9/21/04 revealed the previous fusion of C 6-7 and disk protrusion on the right hand side at C 5-6. There was a normal neurological exam on 7/13, and then on 8/17, there was continued pain with weakness in wrist extension. The RME physician reviewed physical therapy notes (plural) that the patient did not have pain. The request did state that the radiculopathy was getting worse and the patient needed surgery. Past medical history reviewed by the RME stated the patient had three previous injuries. First in May 1995 he was hit on the head, which resulted in surgery in 1996. In 1998, he had another injury treated with an epidural injection and recovered after four months. A small sample of the previous examination from the RME revealed that patient had full range of motion of the cervical spine with pain on extension, and grip strengths were equal. The girth of the forearm and arm were relatively symmetric. There were no gross sensory deficits, and the lower extremity exam was within normal limits. Unfortunately, the remaining finding on examination, impression, and recommendation was not submitted for perusal.

REQUESTED SERVICE

Anterior cervical discectomy/fusion/allograft/plating are requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reason for the continued denial for elective surgery is based on the information that the patient had benefited in the past from conservative care, which the current treating physician appears unwilling to attempt. The treating physician stated that previous attempts to conservative care failed and resulted in surgery, but does not mention that there was an intervening injury where there was a satisfactory recovery. It is revealed in limited pieces of information, that the patient has not benefited from medications or injections for this injury, and although there is some report of cascading findings between visits a months apart, a subsequent visit after the attending physician's note did not appear to have the same conclusion. Unfortunately, the records are

incomplete regarding the RME's report. In regard to elective surgery for pain relief, it is felt that conservative care should be attempted and exhausted and is not truly fair to the patient that the assumption be made that it won't work, therefore, should not try. It would be helpful to have the information derived from previous treatment, particularly the second injury in which four months of conservative care with epidural injection was successful, according to the RME. Providing that the RME findings are true and accurate that the patient does have full range of motion, no evidence of atrophy, and no evidence of significant motor sensory deficit, it appears reasonable to exhaust conservative care prior to the conclusion of necessary surgery. It is with the understanding that the requesting physician is a patient advocate, and that a surgeon is recommending the treatment he feels is necessary and is also with the understanding that an independent physician does not carry the same responsibility as a treating physician. As long as the proposed surgery is an elective consideration, confirmation of the current findings relative to the previous treatment and true exhaustion of conservative effort, including medication injection etc., in the patient's behalf should be strongly pursued. Spine surgery is not without risk, that can include dysphagia, esophageal perforation, infection, permanent nerve damage, failure of fixation, migration of hardware, pseudoarthrosis, etc. Unfortunately, a complete RME report was not available for perusal, but a portion of it implied that the patient did not have progressive neurologic deficits to require emergent/urgent decompression.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings / Appeals Clerk
P.O. Box 17787
Austin, Texas 78744
Fax: 512-804-4011

The party appealing this decision shall deliver a copy of its written request for a hearing to other party involved in this dispute.

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 15th day of October, 2004.